



Texas Department of Insurance

Division of Workers' Compensation

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARRIS METHODIST OF FORT WORTH
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name

OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative Box

Box Number 42

MFDR Tracking Number

M4-07-3696-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim meets all of the criteria defined by the SOAH docket and should have been reimbursed \$47,247.36; however; the carrier paid \$18,861.55 which is the per diem and carve-outs. In order for the carrier to be compliant with rule 134.401 and the lead Stop-Loss SOAH docket, the carrier will need to pay an additional \$28,385.81."

Amount in Dispute: \$28,385.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|-------------------|-------------------|------------|
| August 10, 2006 through August 21, 2006 | Inpatient Surgery | \$28,385.81 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on February 9, 2007.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 14, 2006

- 112-Payment adjusted as not furnished directly to the patient and/or not documented.
- 864-Invoice necessary for reimbursement.
- 877-999-report necessary for reimbursement. Please resubmit with appropriate report.
- 885-999-Review of this code has resulted in an adjusted reimbursement of \$0.00.
- 885-999-Review of this code has resulted in an adjusted reimbursement of \$12,298.00.
- 900-Based on further review, no additional allowance is warranted.
- 975-640-Nurse review in-patient hospitalization/facility/supply house.
- D19-Claim/service lacks Physician/operative or other supporting documentation.
- W1-Workers Compensation state fee schedule adjustment.
- W4-No additional reimbursement allowed after review of appeal/reconsideration.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former Division rule at 28 TAC §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 823.00. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. The requestor asks for reimbursement under the stop loss provision of the Division's *Acute Care Inpatient Hospital Fee Guideline* found in 28 Texas Administrative Code §134.401(c)(6). The requestor asserts in the position statement that "This claim meets all of the criteria defined by the SOAH docket and should have been reimbursed \$47,247.36; however; the carrier paid \$18,861.55 which is the per diem and carve-outs. In order for the carrier to be compliant with rule 134.401 and the lead Stop-Loss SOAH docket, the carrier will need to pay an additional \$28,385.81." 28 Texas Administrative Code §134.401(c)(6), effective August 1, 1997, 22 TexReg 6264, states, in part, that "The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate." As stated above, the Division has found that the primary diagnosis is a code specified in 28 Texas Administrative Code §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to 28 Texas Administrative Code §134.1.
3. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the

requestor position for each disputed fee issue.” Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of 28 Texas Administrative Code §133.307(c)(2)(F)(iv).

4. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
- The requestor's position statement states that “This claim meets all of the criteria defined by the SOAH docket and should have been reimbursed \$47,247.36; however; the carrier paid \$18,861.55 which is the per diem and carve-outs. In order for the carrier to be compliant with rule 134.401 and the lead Stop-Loss SOAH docket, the carrier will need to pay an additional \$28,385.81.
 - The requestor does not discuss or explain how additional payment of \$28,385.81 would result in a fair and reasonable reimbursement.
 - The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per Division rule at 28 TAC §134.401(c)(6).
 - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
 - The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:
“A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”
 - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
 - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.307(c)(2)(F)(iv) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

Signature

Medical Fee Dispute Resolution Manager

Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.